for which the grant was intended.

(b) Contracts, grants, gifts, and income from endowments from private sources, or state and/or local governments, used to purchase allowable program items should not be offset by the ICF/MR provider prior to reporting on the cost report. All such funds which are properly allocable to the cost report should be reported on an ICF/MR provider's cost report, as well as any allowable costs to which the unrestricted funds were applied.

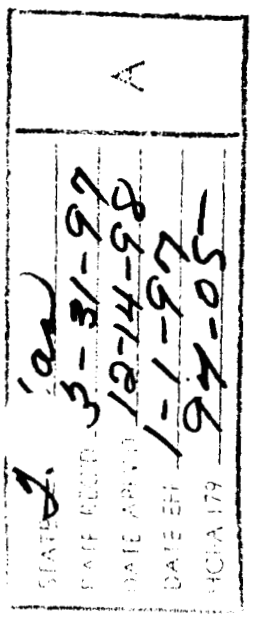
(c) Nonroutine revenues such as income from operations not associated with providing ICF/MR services should be offset or reduced by the related expenses prior to reporting the revenue on the cost report. Expenses related to providing these types of nonroutine operations are unallowable costs. If nonroutine operating expenses, (including overhead costs) generate nonroutine operating expenses in excess of nonroutine operating revenues, the net nonroutine operating expenses are not allowable costs.

6. **Losses resulting from theft or embezzlement.** Losses resulting from theft or embezzlement of property or funds of consumers held in trust by the ICF/MR provider are not allowable costs.

7. **Direct reimbursement.** Any expenses directly reimbursable to the ICF/MR provider which are considered outside the reimbursement payment system are not allowable costs.

8. **Charity or courtesy allowance.** A charity allowance is a reduction in normal charges due to the indigence of the consumer or resident. A courtesy allowance is a reduction in charges granted as a courtesy to certain individuals, such as physicians and clergy. These allowances themselves are not costs since the costs of the services rendered are already included in the ICF/MR provider's costs.

9. **Partial allocation of expenses for items not used entirely in the provision of ICF/MR services.** Whenever otherwise allowable expenses for facilities, materials, supplies, or services are attributable partially to personal or other business interests and partially to ICF/MR services, the latter portion may be allowed on a



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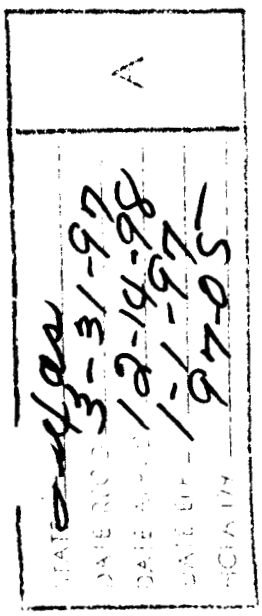
pro rata basis if the proportion used for ICF/MR services is well-documented.

10. **Related-party transactions.** Allowable costs are those which result from arm's length transactions involving unrelated parties. In related-party transactions, the allowable cost is limited to the cost to the related party, either the actual purchase prices paid by the related party or to the usual and customary charges for comparable goods and services, whichever is less. Two or more individuals or organizations constitute related parties whenever they are affiliated or associated in a manner that entails some degree of legal control or practical influence of one over the other. This can be based on common ownership, past or present mutual interests in any type of enterprise, or family ties.
11. **Administrative Penalties.** Fines assessed as administrative penalties and costs or interest associated with such penalties are unallowable.
12. **Other Benefits.** Costs for which a consumer had Medicare Part A or B benefits, third-party payor benefits, vendor drug coverage, or any other benefits are unallowable.

IV. Cost Data

A. Cost Reporting

1. **Types.** There are four types of cost reporting required by TDMHMR:
   (a) Full cost reports;
   (b) Comprehensive cost reports for non-state operated facilities;
   (c) Uniform direct services cost reports; and
   (d) Special Cost Surveys.
2. **Frequency.**
   (a) Full cost reports are completed by state-operated providers every year. State-operated facilities complete full cost reports on a state fiscal year basis.
   (b) Comprehensive cost reports are completed by a representative sample of non-state operated providers at least every four years.
   (c) Direct services cost reports, as specified in II.A.1. and II.C.2. of Attachment 4.19-D (ICF/MR), are completed by all non-state operated providers on an annual basis, based



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upon the provider's fiscal year.

(d) Special surveys are completed as requested.

3. **Integrity of cost data.**

(a) TDMHMR conducts desk reviews of all reported costs to ensure that the financial and statistical information submitted in the reports conforms to all applicable rules and instructions. The basic objective is to verify that each provider's reports:

(1) Display financial and statistical information in the format required by TDMHMR;

(2) Report expenses in conformity with TDMHMR's lists of allowable and unallowable costs, as defined in Section III of Attachment 4.19-D (ICF/MR); and

(3) Follow generally accepted accounting principles [except as otherwise specified in the lists of allowable and unallowable costs as specified in Section III.B. of Attachment 4.19-D (ICF/MR)], or as otherwise permitted in the case of governmental entities operating on a cash basis.

(b) TDMHMR verifies the information by:

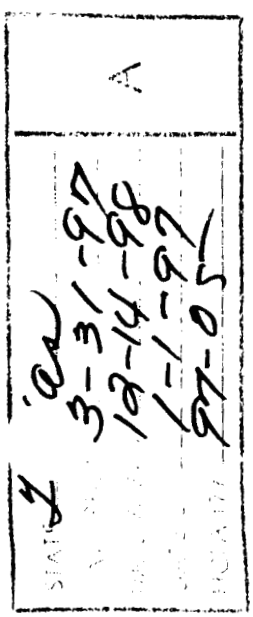
(1) Comparing each provider's reported costs to past patterns of expenditures for similar services, results of previous on-site audits, normal operating cost relationships, and industry average costs.

(2) Reviewing each provider's reported costs to search for reported unallowable costs, omitted allowable costs, and overstated or understated allowable costs.

(3) Checking for completion of required information, mathematical accuracy, and adjusting improperly prepared reports.

(c) **Audits.** TDMHMR will conduct on-site audits of reported costs as necessary to verify the integrity of the cost data.

(d) **Exclusions of Certain Reported Costs.** Providers are generally responsible for eliminating all unallowable expenses from the cost report. TDMHMR reserves the right to exclude any unallowable expenses included in the cost report and to exclude from the rate



base any cost reports which do not reflect economic and efficient operation.

(e) **Adjustments to Certain Reported Costs.** TDMHMR adjusts costs reported by providers to ensure that costs used in rate analysis are reasonable and necessary for the provision of long term care services. TDMHMR reserves the right to reduce or eliminate costs deemed excessive or unnecessary from individual cost reports and to place limits on particular categories of costs to ensure that they reflect economic and efficient use of resources.

1. **Fixed Capital Asset Costs.** Annual increases in fixed capital asset costs to be included in the rate base will be limited consistent with current Medicaid regulations , the Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1985.
2. **Occupancy Adjustments.** TDMHMR adjusts the facility and administration costs of providers with occupancy rates below a target occupancy rate. The target occupancy rate is the lower of:
   (a) 85 percent or
   (b) the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost reporting periods included in the base.
3. **Revenue Offsets.** TDMHMR offsets against reported expenses certain types of non-operating revenues, after reasonable allowances for overhead costs. Types of revenues offset against costs include: income from beauty and barber shop operations, prior year over-payments, vending machine proceeds, gift shop receipts, and payment for meals by employees and guests. Interest income is used to offset working capital interest expense, not to exceed total interest costs. An exception is interest income from funded depreciation accounts or qualified pension funds, which is not treated as a revenue offset item. For facilities reporting

central office overhead expenses, interest income is offset against interest expenses before the allocation of central office costs to individual ICFs/MR.

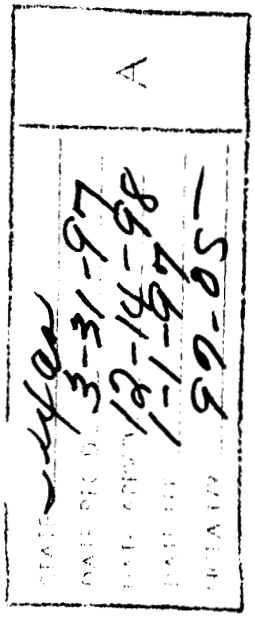
V. Reimbursement Determination.

TDMHMR reimburses Texas Medicaid ICF/MR providers for services provided to eligible consumers in ICF/MR facilities. The Texas Department of Mental Health and Mental Retardation Board determines reimbursement rates at least annually for two types of facilities: state-operated and non-state operated.

A. **Rate Determination for State-operated Facilities.** The Texas Mental Health and Mental Retardation Board determines reimbursement annually. State-operated rates are effective May 1, 1996. Rates are facility-specific, determined prospectively (with the inflators outlined in Section VI), cost related, and do not vary by size or level of need.

1. **Description of rate class.** The state-operated facility rate class consists of all ICF/MR facilities that are operated by TDMHMR.
2. **Determination of state-operated facility rates.** Eligible state-operated facilities are reimbursed in the following manner:
   (a) The rate for each facility's projected per diem cost is based on the total projected allowable costs for selected cost centers divided by the total days of service the facility delivered in the cost reporting period.
      (1) Rates for state-operated ICFs/MR are based on the most current available cost report.
      (2) Rates for newly certified facilities that have not operated long enough to have current available cost reports (as defined in section VA2(d)of Attachment 4.19-D, ICF/MR) will be based on a pro forma model. The model will be derived as follows:

      A six bed or less state-operated facility's rate will be the average of all similarly sized state-operated facilities per diem rates for that particular rate year.



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After the first 90 days of operation, when facilities have a sufficient number of days of service to represent incurred operational costs, they will be required to submit three month cost reports. Per diem reimbursements that are based on the costs incurred in the first quarter of operation will be set within six months of each facility's certification. Each facility will be operating on its historical costs within 6 months of certification.

(b) Since provision is made to ensure that reasonable and necessary costs are covered, state-operated ICF/MR facilities do not qualify for additional supplemental reimbursement for individuals whose needs require a significantly greater than normal amount of care.

(c) Cost reports from facilities in this class will not be included in the cost arrays that are used to determine reimbursement rates for other classes of providers.

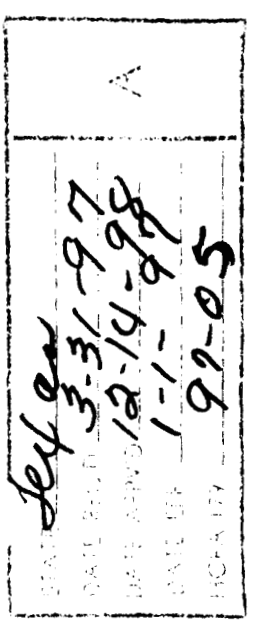
B. **Non-state operated facilities.**

1. **Classes of facilities.** Classes of non-state operated facilities are based upon facility size. The classes of non-state operated facilities are:

(a) Large facility - a facility with a Medicaid certified capacity of fourteen or more beds as of the first day of the full month preceding the rate's effective date or, if certified for the first time after a rate's effective date, as of the date of the initial certification;

(b) Medium facility - a facility with a Medicaid certified capacity of nine through thirteen beds as of the first day of the full month preceding the rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification; and

(c) Small facility - a facility with a Medicaid certified capacity of eight or fewer beds as of the first day of the full month preceding the rate's effective date or, if certified for the first time after a rate's effective date,



as of the date of initial certification.

2. **Rates effective date.** The TDMHMR Board approves rates to be effective January 1st of each calendar year unless otherwise specified by the Board.

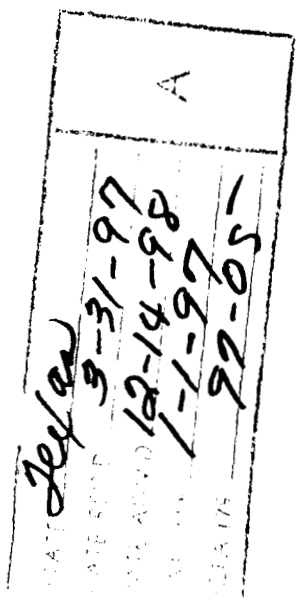
3. **Per diem rate.** Non-state operated facility rates include payment for a full 24-hours of ICF/MR services except as provided for in V.B.7 of Attachment 4.19-D (ICF/MR) regarding durable medical equipment and page 17 of Attachment 4.19-B (ICF/MR) regarding dental services.

4. **Levels of need.** Non-state operated per diem reimbursement rates will be differentiated based on consumer level of need and the facility class. The level of need system is a classification system that differentiates rates based on the needs of the individuals served.

   (a) The level of need classification is based upon the Inventory For Client and Agency Planning (ICAP) service levels. Individuals are classified in the intermittent category if they have an ICAP service level of 7, 8, or 9; individuals are classified at a limited level if they have an ICAP service level of 4, 5, or 6; individuals are classified at an extensive level if they have an ICAP service level of 2 or 3; and individuals are classified as pervasive if they have an ICAP service level of 1.

   (b) For individuals who have extraordinary medical needs or behavioral challenges, there is an opportunity to adjust the level of need to more appropriately reflect level of service needed. Individuals who receive 3 or more hours of nursing service a week are eligible to be moved to the next higher level of need category. An individual cannot move to the next higher level of need category for both a medical and behavior reason. For individuals who have dangerous behaviors that require 1:1 supervision at least 16 hours per day, a special category has been developed, pervasive plus. The levels of need are defined as follows:

      (1) intermittent- infrequent personal care and/or regular supervision is required to meet the consumer's needs;



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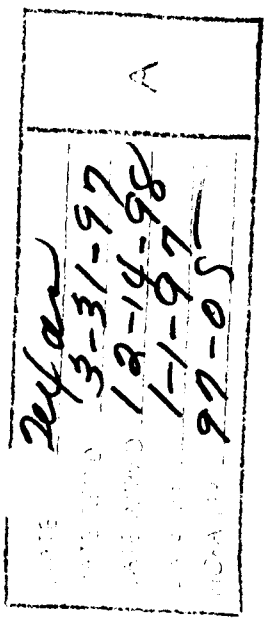
(2) limited - limited personal care and/or close supervision is required to meet the consumer's needs;
(3) extensive - extensive personal care and/or constant supervision is required to meet the consumer's needs;
(4) pervasive - total personal care or intense supervision is required to meet the consumer's needs; and
(5) pervasive plus - the consumer requires a constant daily staffing ratio of 1:1 on an average of 16 waking hours per day.

5. **Uniform rates.** Except for demonstration or pilot projects involving experimental classes, reimbursement rates for levels of need are uniform state wide for the same class of non-state operated facilities.

6. **Prospective rates.** Historical costs are analyzed by component and adjusted by inflationary indices to be prospective in nature with no annual settlement. The rate setting parameters or decisions within each model rate are developed based on reasonable and adequate costs which the state determines appropriate to provide services in an economic and efficient manner.

7. **Medical services and durable medical equipment covered as ICF/MR services.** Individuals that reside in non-state operated ICF/MR facilities receive medical and dental services through the Medicaid identification card. With the exception of the durable medical equipment described in subparagraphs a-d any medical expenses other than services covered elsewhere in the State plan are the responsibility of the ICF/MR provider. TDMHMR will pay ICF/MR providers for the actual cost of a consumer's durable medical equipment costs reimbursed through a voucher system if:
(a) the cost of the equipment exceeds $1,000;
(b) the ICF/MR provider receives prior approval from TDMHMR to purchase the equipment;
(c) the ICF/MR provider submits a voucher to TDMHMR for the cost of the equipment; and
(d) the consumer is eligible for Medicare



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benefits, the ICF/MR provider has submitted a Medicare claim and received a response to the claim prior to requesting payment from TDMHMR. Payment by TDMHMR is limited to $5,000 for durable medical equipment per consumer per year. Costs reimbursed through the voucher system are not used in setting the reimbursement rates for ICF/MR services.

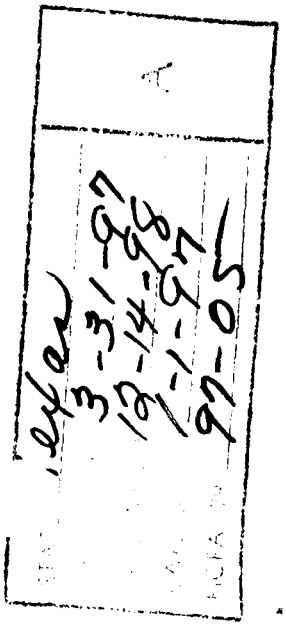
8. **Cost components.** Medicaid rates are paid to non-state operated ICF/MR providers as determined by the processes outlined in V.B.3.-V.B.11. of Attachment 4.19-D (ICF/MR). The modeled rates are based on cost components appropriate for an economic and efficient ICF/MR provider of quality services as shown below. The determination of these components is based on historical costs; and financial, statistical, and operational information collected from a representative sample of ICF/MR providers. They represent the best judgment of the state as to the reasonable and adequate reimbursement required to cover the costs of economic and efficient ICF/MR facilities. Included in the costs are:

(a) Direct service costs, including salaries, wages and benefits for the appropriate level of direct care staffing for the level of need. Direct care supervision salaries, wages and benefits and contracted direct care services are also included.

(b) Non-personnel operated expenses which include direct service staff travel and mileage costs, program related supplies, training costs, drugs and medical supplies, transportation equipment and related costs, durable medical equipment and other related costs.

(c) Office and facility related expenses including housekeeping/linen and bedding supplies, maintenance supplies, contract maintenance and repairs, building and building equipment, rental/lease and depreciation, salaries and benefits for office/facility related personnel, land and leasehold improvement, depreciation/amortization, mortgage interest, property taxes, property insurance, and utilities and telecommunications.

(d) Administration expenses which include salaries and benefits for administrative personnel such



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as facility administrator, clerical support and central office staff, management contract fees, professional service fees, contracted administrative staff, general liability insurance, interest expense on working capital, allowable advertising, travel and seminars, dues and subscriptions, office supplies, central office costs and other office expenses.

(e) Professional consultation expenses including professional contracted services for non-direct care staff(e.g., Medical Director, consulting pharmacists).

9. **Data analysis.** For the initial model based rates, a representative sample determined by an independent consultant was chosen to include providers of different sizes, providers who serve individuals with different level of care needs, and geographic areas of the state. Both public and private non-state operated providers were chosen. Cost, financial, statistical, and operational information was collected during the site visits performed by an independent consultant. These data were collected from cost reports and the service providers' accounting systems. The same process will be used with the rebasing sample. The panel reviews and analyzes the fiscal year 1996 state wage data, the fiscal year 1994 cost data and the fiscal year 1995 sample data from 17 ICF/MR service providers statewide. The base year is calendar year 1997. The rate year is each calendar year thereafter.

(a) The level of need assessment criteria is used to identify ICF/MR consumers according to the level of resources needed to care for them. TDMHMR uses the level of need criteria with available cost data to calculate rates by level of need and facility size (see section V.B.4. of Attachment 4.19-D).

(b) All non-state operated ICF/MR providers will be required to prepare and submit annual Fiscal Accountability Cost Reports (direct service wages, benefits, contract services, and staffing information). The state will use this information to compare direct service costs to direct service reimbursement and to determine if rates need to be rebased more